Collaboration Between CLINICIANS & CUSTODY Staff Benefits the Entire Prison

By Sherry Macpherson

Due to the large number of inmates who have mental health disorders, clinicians are often asked to provide custody staff an overview of mental health issues. When that happens, it is the trainer's responsibility to give a presentation that is not only informative but also relevant to the trainees. Trainers should apply the tools of the clinician to the prison setting in a relevant manner.

Prison housing units are filled with inmates who have little more in common with one another than a criminal conviction. Beyond that, inmates represent a diverse population, varying by type and severity of crime, economic status, educational background, ethnicity and cultural histories. Inmates also vary with respect to their level of mental health functioning. Deviations in mental health dysfunction result in inmates who are incapable of performing in what is considered the "normal range of behavior." Thirty years ago, many of today's inmates would have been residents of psychiatric hospitals; however, depopulation of psychiatric wards became a cultural trend in the 1970s, according to the book *Understanding and Changing Criminal Behavior* (1980) by Michael J. Lillyquist. Unfortunately, the mainstreaming of psychiatric patients into the general population resulted in a second wave of institutionalization. Prison sentences have taken the place of hospital commitments, which has resulted in a prison population saturated with inmates who do not measure up to the level of accountability and performance that a prison mandates. Individuals with mental health disorders often become inmates with coping difficulties, impulse control problems and/or problems simply keeping in touch with the reality of their surroundings.

For the most part, prisons are highly structured settings, and the higher the security status, the more restrictive the structure, meaning additional rules and less freedom. Inmates who suffer from mental illnesses usually end up at the high end of security designations due to behavioral maladjustment or poor professional reports that offer prognoses of unpredictable, possibly aggressive, self-destructive or bizarre behavior. Thus, the inmates who are expected to have the most trouble controlling their behavior are subjected to the maximum number of rules and regulations. A more restrictive structure is justified because it is an attempt to protect others, while minimizing acting out. Some inmates with mental health disorders will find their way to single cells in segregated housing; others will be placed in special housing units with treatment components. However, the majority of inmates with mental health disorders are found in the general population with medium- to maximum-custody status in double-celled housing or, worse yet, in dormitory settings.

Coping with the mentally disabled is generally viewed as a job for clinicians. Psychiatrists and psychologists are part of a team of professionals who identify and treat inmates in need. However, clinicians are few and far between in most prisons. While they are usually in sufficient numbers to identify and diagnose special needs inmates, there are not enough to routinely monitor at-risk inmates. In the everyday world of prisons, correctional officers are the staff who are in the position to monitor the daily behavior of inmates. Correctional officers regulate life on the housing units, movement through the prison and work completed on assigned details. Clinicians become involved during assessment, periodic treatment and crisis situations. They are not in a position to observe early warning signs of deterioration; rather, precursors to a breakdown are usually first observed by correctional officers or other inmates who interact daily with a problem individual.

As a result, there should be a communication system in place that fosters the timely referral of observed warning signs to treatment staff. Collecting information that reveals that a problem was festering for some time after a crisis occurs is obviously too late to prevent such a crisis. Generally, early preventive measures and custody staff's timely sharing of information with treatment staff can benefit the special needs inmate and protect the entire prison community.

The Role of Custody Staff

In *Correctional Officer Resource Guide*, *Third Edition* (1997), Donald Bales points out that correctional officers supervise inmates as they eat, sleep, work and exercise. They control inmate movement, protect the inmates and maintain security. They "see inmates' subtle actions, reactions and interactions," Bales said. All of this information is observed in the daily routine of custody staff. However, too often, important information is not relayed in a timely manner to treatment staff who may be able to ward off undesirable conduct. Clinical staff can be valuable in a number of ways, including counseling inmates about their existing dysfunction, predicting an expected pattern of behavior based on their assessment, prescribing medication that can address the problem, and/or removing the inmates from general population housing or their job assignment based on their prognosis. Unless picked up on a routine evaluation, the clinician is not able to observe the inmate at risk. Someone has to alert clinical staff to an existing problem or the inmate will continue undetected in the general population until a crisis occurs. Correctional officers are in the best position to observe and refer inmates for assessment.

There are many questions raised by a directive to have custody staff act as advance scouts for clinical staff. Are custody staff being adequately trained to identify the signs of active psychosis? Are they trained to understand the diversity of diagnostic categories and the implications of a diagnosis? Is it their responsibility to have a working knowledge of mental health disorders? Can the tools of the clinician be adapted so they are relevant to custody staff? Are the lines of communication between custody and clinical staff open? Bales sums it up by

saying, "Correctional officers are not in a position to treat these conditions, but it is important to both the inmate and institution that officers appraise inmates' behavior well enough to respond to problems quickly, efficiently and appropriately." Sometimes the courts provide the initiative for a correctional system to implement a program for addressing the needs of the mentally disabled. Such was the case in New Jersey where, as a result of a class-action lawsuit, a mandate addressing these questions came from the courts. As part of the 1999 *C.F. v. Terhune* settlement agreement, the New Jersey Department of Corrections was directed to train officers in the early warning signs of mental illness as well as in the understanding and management of mentally ill inmates.

Presenting Relevant Information

For clinicians to train custody staff in a vocabulary that is useful to both, clinicians need to connect the information to the everyday work of correctional officers. The classifications of mental disorders found in the *Diagnostic and Statistical Manual of Mental Health Disorders* (DSM-IV) may not be relevant to custody staff until they are translated into examples of how inmates with different diagnoses may eat, sleep, work and socialize with others in an institutional setting. If the differences found among schizophrenics, bipolars and those with antisocial personality disorders are not presented in a context of how these differences translate into daily functioning, then the connection of relevance is missed. Trainers must be familiar with the work of the trainees as well as the world of mental health dysfunction to make their information useful.

A lecture should begin with the general concept of labeling abnormal versus normal behavior and end with delineating custody staff's role in treatment issues. It should cross-reference the topics generally covered in a classroom lecture on mental health disorders with applications common to a correctional setting.

When presenting the DSM-IV categories, the lecturer should provide examples of how these classifications play out in prison. For example, explain that those with developmental disorders, such as a mildly retarded inmate, will usually take longer to learn the paramilitary routine of a prison. This inmate also would be a target for exploitation, both socially and sexually, making him or her a potential victim. Property and food may be taken from this inmate to the point that he or she is robbed of standard prison distributions. In addition, this inmate would have a tendency to follow and trust the wrong role models; he or she would be easily misled and less likely to problem-solve or anticipate the consequences of a type of behavior. This would become an issue for custody staff who would have to write numerous disciplinary charges and then take the time to enforce sanctions.

Each of the disorders common to prison carries with them an expected pattern of behavior that can be defined by mental health professionals. To take that pattern and express it in the context of prison life results in information that is valuable to custody staff.

The lecture should include the following topics: abnormal versus normal behavior, differences being a matter of degree, looking for levels of competence in the setting, the standards and values of the prison setting, community versus prison expectations, recognizing patterns using symptoms and traits, the function of the clinician, treatment, referral to other staff, prognosis, predicting expected behaviors, making recommendations on expectations, periodic reassessment, diagnostic categories, the purpose of the DSM-IV, disorders common to prison, the custody role, observation, establishing lines of communication, determining what information is relevant and conflicts between custody and treatment.

Training Exercise: Cellmate Match

Once the lecture is presented and questions are answered, the trainer can present the cellmate match task, which attempts

Table 1. Cellmate Match Examples

1.	26-year-old with an IQ of 65 who reads at a first-grade level. He tends to be dependent and is a follower. He is incarcerated for four counts of selling drugs on a street corner near a school zone.	**A.**	38-year-old inmate who works for the education department as a paraprofessional teaching other students. Never gets in trouble. Cell is next to the officer's desk and he is doing a lot of time.
2.	48-year-old highly nervous inmate, who has obsessive compulsive traits of washing his hands constantly, taking four showers a day and making repeated complaints about germs, laundry and food. He is incarcerated for the manslaughter of his wife.	**B.**	48-year-old inmate who is a porter working for the housing officer. He is the main inmate the officer counts on for obtaining information about other inmates and to get things done. He has been in and out of prison since he was 18.
3.	30-year-old paranoid inmate who cycles through active psychosis about every six months. During remission, he functions OK on medication. When actively psychotic, he hears voices and accuses everyone of stealing his property and his mind. He is incarcerated for terroristic threats and stalking.	**C.**	29-year-old inmate who has a history of suicide attempts during which he repeatedly cut himself. He has been stable for one year and is working in the medical area as a porter. He is very nervous and seems to stay awake most of the night.
4.	51-year-old depressive inmate who has been in and out of rehabilitation and tends to become worse after phone calls home. He has difficulty getting up in the morning and will spend his whole day in bed if allowed. He is in prison for vehicular manslaughter.	**D.**	25-year-old who works third shift in food services. When awake on the housing unit, he watches T.V. in the dayroom, plays cards and works out in the yard. He tends to be in the middle of things when there is a problem on the unit.

to make the connection between the psychological concepts presented and an actual application to the prison setting. Realistically, custody staff are not presented with a psychological profile when a new inmate is assigned to a housing unit because much of this information is considered confidential. It is reviewed in classification committee meetings where the custody officers are not routine participants. However, in the course of living on a unit and interacting on a daily basis, the regularly assigned custody staff come to know the inmates, their routines, associates and habits. For the purpose of this task, custody staff are provided with profiles of inmates with mental health problems and asked to match cellmates for a two-person cell with inmates already on the housing unit (see Table 1). The focus of the exercise is to extract the information given in the lecture and apply it to a housing unit.

The class should be divided into groups of about five people each. The trainer explains there are no wrong answers but some matches will result in better outcomes than others. A discussion should follow where the groups identify the choices made and relate them to information provided in the lecture.

Processing the Cellmate Match

The trainer can take the exercise and process it in several ways since the purpose is to generate discussion and put the trainees in the mind-set of thinking from a treatment orientation. Emphasis should be placed on applying clinical concepts to the daily routine of custody staff. Right or wrong answers are not important in this exercise because the exercise is ambiguous enough to generate multiple responses. As long as the choices can be justified as an appropriate alternative for matching two cellmates from a treatment perspective, the choice is acceptable.

The trainer can simply go group by group, recording cellmate choices made for each of the inmates on the left. Once recorded, the trainer should go back and have each group justify the matches, explaining what influenced the choices. The trainer should facilitate the discussion by exploring behavioral outcomes that could result. Since all inmates have to be slotted into the daily life of the housing unit, the trainer should point out that the goal is to assign them in a way that they can perform at their maximum level with the least amount of disruption to the unit. In assigning cellmates, the goal is to make the best fit, which can benefit the individual inmates as well as the entire prison population. It also can result in making custody staff's jobs easier.

A second suggestion is to have the groups match the special needs inmates with the diagnostic categories defined in the lecture. This provides more practice in becoming familiar with the mental health classifications and will demonstrate that often, multiple categories apply to one person.

Table 2. Job Examples

Pantry Worker	Inmate stays on his or her own housing unit and distributes meals to other inmates.
Laundry Worker	Inmate is responsible for washing and drying clothes on the housing unit.
Housing Unit Runner	Inmate stays in own unit and works doing housing sanitation chores as assigned by the housing unit officer.
Paralegal	Inmate must pass a paralegal course and works out of the law library assisting other inmates with disciplinary charges and access to legal material and the courts.
Ground Maintenance	Inmate works on the prison grounds, under officer supervision, picking up trash and sweeping.
Recreation	Inmate assists the civilian supervisor in putting out schedules and coordinating sports teams and events.
Paint Detail	Inmate paints housing units/offices/classrooms under the direction of an officer.
Teacher Aide	Inmate assists civilian teachers in the classroom with tutoring, grading papers and making presentations.
Food Service	Inmate works in the kitchen area making and distributing food and cleaning up.
Commissary Worker	Inmate assists the civilian supervisor with filling and distributing commissary orders for inmates.

Training Exercise: Job Assignments

Once the cellmate match is completed, the trainees are asked to stay in the same groups and assign each of the special needs/mental health inmates to institutional jobs from the list in Table 2. A brief description is included to give some idea of what the job entails. There are more jobs than inmates but no two inmates should be assigned the same job.

Like the cellmate match, the purpose of the job assignments task is to give the trainees an opportunity to apply the information from the lecture to the daily job of a correctional officer. Again, there are no wrong answers, but choices made should have reasons that line up with clinical reasoning.

Conclusion

Upon completion of the tasks and discussion, the trainer can summarize the contents of the lecture. This can include a review of processing information about an inmate and using it in a positive manner that may prevent behavioral problems on a housing unit and in a job. The benefits of applying clinical information to the prison setting should be highlighted, and the need for open lines of communication between custody and clinicians should be stressed.

Collaborative efforts between clinical and custody staff can result in many gains for the entire prison. Behavioral differences among inmates are explained with respect to various diagnostic labels as well as interpreting those labels that help predict response patterns. Also, coping skills for managing special needs inmates are proposed and discussed with applications suggested for maximizing inmates' potential adjustment. Finally, clinical and custody staff jointly pursue the goal of maintaining the orderly running of the institution by identifying where the two roles intersect and blend for mutual gain.

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Vol. 66, No. 2 with permission from:
The American Correctional Association, 4380 Forbes Blvd., Lanham, Maryland 20706